FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044172

Facility Name: MAPLE CREST CARE CENTRE

Address: 4452 SQUAW PRAIRIE ROAD (Number) BELVIDERE (City) 61008 (Zip Code)

County: BOONE

Telephone Number: (815) 547-6377 **Fax #** (815) 547-3857

IDPA ID Number: 36-4253834

Date of Initial License for Current Owners: 02/01/99

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) SHAEL BELLOWS

(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA/PARTNER

(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD
3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	78	Skilled (SNF)	78	28,548	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	78	TOTALS	78	28,548	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,876	994	1,308	4,178	8
9	SNF/PED					9
10	ICF	14,331	7,604	733	22,668	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,207	8,598	2,041	26,846	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.04%

D. How many bed-hold days during this year were paid by Public Aid?
194 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
COUNTY JAIL MEALS

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 1217

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	180,615	12,599	7,452	200,666		200,666	(349)	200,317			1
2	Food Purchase		189,199		189,199	(6,398)	182,801	(167,902)	14,899			2
3	Housekeeping	61,279	22,205	0	83,484		83,484	463	83,947			3
4	Laundry	23,530	11,081	936	35,547		35,547	413	35,960			4
5	Heat and Other Utilities			84,463	84,463		84,463	0	84,463			5
6	Maintenance	51,088	29,543	43,521	124,152		124,152	(457)	123,695			6
7	Other (specify):*			2,809	2,809		2,809	0	2,809			7
8	TOTAL General Services	316,512	264,627	139,181	720,320	(6,398)	713,922	(167,832)	546,090			8
	B. Health Care and Programs											
9	Medical Director			4,350	4,350		4,350	0	4,350			9
10	Nursing and Medical Records	922,255	44,457	213,519	1,180,231		1,180,231	(8,595)	1,171,636			10
10a	Therapy	68,045		4,707	72,752		72,752	0	72,752			10a
11	Activities	64,429	1,883	1,093	67,405		67,405	(883)	66,522			11
12	Social Services	24,354		2,842	27,196		27,196	0	27,196			12
13	Nurse Aide Training			0				0				13
14	Program Transportation			0				0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	1,079,083	46,340	226,511	1,351,934		1,351,934	(9,478)	1,342,456			16
	C. General Administration											
17	Administrative	57,800		224,612	282,412		282,412	(220,087)	62,325			17
18	Directors Fees			0				0				18
19	Professional Services			161,754	161,754		161,754	1,160	162,914			19
20	Dues, Fees, Subscriptions & Promotions			32,690	32,690		32,690	(21,316)	11,374			20
21	Clerical & General Office Expenses	57,320	20,019	20,423	97,762		97,762	68,612	166,374			21
22	Employee Benefits & Payroll Taxes			234,447	234,447	6,398	240,845	0	240,845			22
23	Inservice Training & Education			6,819	6,819		6,819	0	6,819			23
24	Travel and Seminar			0				5,019	5,019			24
25	Other Admin. Staff Transportation			2,950	2,950		2,950	0	2,950			25
26	Insurance-Prop.Liab.Malpractice			41,591	41,591		41,591	2,392	43,983			26
27	Other (specify):*			20,145	20,145		20,145	(20,145)				27
28	TOTAL General Administration	115,120	20,019	745,431	880,570	6,398	886,968	(184,365)	702,603			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,510,715	330,986	1,111,123	2,952,824		2,952,824	(361,675)	2,591,149			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			28,472	28,472		28,472	(9,614)	18,858			30
31	Amortization of Pre-Op. & Org.			11,833	11,833		11,833	0	11,833			31
32	Interest			56,877	56,877		56,877	(3,554)	53,323			32
33	Real Estate Taxes			29,930	29,930		29,930	0	29,930			33
34	Rent-Facility & Grounds			29,167	29,167		29,167	6,540	35,707			34
35	Rent-Equipment & Vehicles			6,280	6,280		6,280	3,314	9,594			35
36	Other (specify):*							0				36
37	TOTAL Ownership			162,559	162,559		162,559	(3,314)	159,245			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		39,559	50,995	90,554		90,554	0	90,554			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			42,822	42,822		42,822	0	42,822			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		39,559	93,817	133,376		133,376		133,376			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,510,715	370,545	1,367,499	3,248,759	0	3,248,759	(364,989)	2,883,770			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(166,235)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(13,860)	30		9
10	Interest and Other Investment Income	(3,554)	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,667)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	0	21		18
19	Entertainment	0	20		19
20	Contributions	(1,250)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(851)	19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	(20,145)	27		24
25	Fund Raising, Advertising and Promotional	(20,214)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(595)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	0	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (228,371)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(119,210)	PG 6	34
35	Other- Attach Schedule VACATION ACC.	(17,408)	PG 5A	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (136,618)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (364,989)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Preview

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.
1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other Adjustments

STATE OF ILLINOIS **Page 5A**

Facility Name **MAPLE CREST CARE CENTRE**

ID# **0044172**

Report Period Beginning: **01/01/2000**

Ending: **12/31/2000**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
	The information listed in B13 thru G43 is from Page 5.				
1	Day Care	0	0	Line 1	(349)
2	Other Care for Outpatients	0	0	Line 2	(167,902)
3	Governmental Sponsored Special Programs	0	0	Line 3	463
4	Non-Patient Meals	(166,235)	2	Line 4	413
5	Telephone, TV & Radio in Resident Rooms	0	0	Line 5	0
6	Rented Facility Space	0	34	Line 6	(457)
7	Sale of Supplies to Non-Patients	0	10	Line 7	0
8	Laundry for Non-Patients	0	4	Line 8	(167,832)
9	Non-Straightline Depreciation	(13,860)	30	Line 9	0
10	Interest and Other Investment Income	(3,554)	32	Line 10	(12,626)
11	Discounts, Allowances, Rebates & Refunds	0	2	Line 10a	0
12	Non-Working Officer's or Owner's Salary	0	0	Line 11	(883)
13	Sales Tax	(1,667)	2	Line 12	0
14	Non-Care Related Interest	0	32	Line 13	0
15	Non-Care Related Owner's Transactions	0	0	Line 14	0
16	Personal Expenses (Including Transportation)	0	25	Line 15	0
17	Non-Care Related Fees	0	20	Line 16	(13,509)
18	Fines and Penalties	0	21	Line 17	(3,185)
19	Entertainment	0	20	Line 18	0
20	Contributions	(1,250)	20	Line 19	(851)
21	Owner or Key-Man Insurance	0	22	Line 20	(22,059)
22	Special Legal Fees & Legal Retainers	(851)	19	Line 21	(784)
23	Malpractice Insurance for Individuals	0	26	Line 22	0
24	Bad Debt	(20,145)	27	Line 23	0
25	Fund Raising, Advertising and Promotional	(20,214)	20	Line 24	0
26	Income & IL Personal Property ReplacementTaxes	0	0	Line 25	0
27	Nurse Aide Training for Non-Employees	0	13	Line 26	0
28	Yellow Page Advertising	(595)	20	Line 27	(20,145)
29	Non-Paid Workers	0	0	Line 28	(47,024)
30	Donated Goods	0	0	Line 29	(228,365)
31	Amortization Expense	0	0	Line 30	(13,860)
32	PAGE 5 - LINE 35 VACATION ACCRUAL	(349)	1	Line 31	0
33	PAGE 5 - LINE 35 VACATION ACCRUAL	463	3	Line 32	(3,554)
34	PAGE 5 - LINE 35 VACATION ACCRUAL	413	4	Line 33	0
35	PAGE 5 - LINE 35 VACATION ACCRUAL	(457)	6	Line 34	0
36	PAGE 5 - LINE 35 VACATION ACCRUAL	(12,626)	10	Line 35	0
37	PAGE 5 - LINE 35 VACATION ACCRUAL	(883)	11	Line 36	0
38	PAGE 5 - LINE 35 VACATION ACCRUAL	(3,185)	17	Line 37	(17,414)
39	PAGE 5 - LINE 35 VACATION ACCRUAL	(784)	21	Line 38	0
40	PAGE 5 - LINE 29 DEFERRED MAINTENANCE		6	Line 39	0
41				Line 40	0
42				Line 41	0
43				Line 42	0
44				Line 43	0
45				Line 44	0
46				Line 45	(245,779)
47					
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1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(349)	0	0	0	0	0	0	0	0	0	0	(349)	1
2	Food Purchase	(167,902)	0	0	0	0	0	0	0	0	0	0	(167,902)	2
3	Housekeeping	463	0	0	0	0	0	0	0	0	0	0	463	3
4	Laundry	413	0	0	0	0	0	0	0	0	0	0	413	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(457)	0	0	0	0	0	0	0	0	0	0	(457)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(167,832)	0	0	0	0	0	0	0	0	0	0	(167,832)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(12,626)	4,031	0	0	0	0	0	0	0	0	0	(8,595)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(883)	0	0	0	0	0	0	0	0	0	0	(883)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(13,509)	4,031	0	0	0	0	0	0	0	0	0	(9,478)	16
	C. General Administration													
17	Administrative	(3,185)	(216,902)	0	0	0	0	0	0	0	0	0	(220,087)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(851)	2,011	0	0	0	0	0	0	0	0	0	1,160	19
20	Fees, Subscriptions & Promotions	(22,059)	743	0	0	0	0	0	0	0	0	0	(21,316)	20
21	Clerical & General Office Expenses	(784)	69,396	0	0	0	0	0	0	0	0	0	68,612	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,019	0	0	0	0	0	0	0	0	0	5,019	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	2,392	0	0	0	0	0	0	0	0	0	2,392	26
27	Other (specify):*	(20,145)	0	0	0	0	0	0	0	0	0	0	(20,145)	27
28	**TOTAL General Administration**	(47,024)	(137,341)	0	0	0	0	0	0	0	0	0	(184,365)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(228,365)	(133,310)	0	0	0	0	0	0	0	0	0	(361,675)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(13,860)	4,246	0	0	0	0	0	0	0	0	0	(9,614)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,554)	0	0	0	0	0	0	0	0	0	0	(3,554)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	6,540	0	0	0	0	0	0	0	0	0	6,540	34
35	Rent-Equipment & Vehicles	0	3,314	0	0	0	0	0	0	0	0	0	3,314	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(17,414)	14,100	0	0	0	0	0	0	0	0	0	(3,314)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(245,779)	(119,210)	0	0	0	0	0	0	0	0	0	(364,989)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number MAPLE CREST CARE CENTRI # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF		SEE ATTACHED LIST OF RELATED		FIRST HEALTH CARE ASSOCIATES, LTD.		MANAGEMENT/
OWNERS		NURSING HOMES		(DIVISION OF FHC ENTERPRISE, INC.)		CONSULTANT
					ROSEMONT	
						REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1	V	10	NURSING	$	FHC ENTERPRISES INC		$ 4,031	$ 4,031	1	4031
2	V	17	ADMINISTRATIV	224,612	MR. BELLOWS OWNS 67.50% OF THIS FACILIT		7,710	(216,902)	2	-216902
3	V	19	PROFESSIONAL FEES		AND 100% OF FHC ENTERPRISE		2,011	2,011	3	2011
4	V	20	DUES & SUBSCRIPTIONS		" "		743	743	4	743
5	V	21	CLERICAL		" "		69,396	69,396	5	69396
6	V	24	TRAVEL		" "		5,019	5,019	6	5019
7	V	26	INSURANCE		" "		2,392	2,392	7	2392
8	V	30	DEPRECIATION		" "		4,246	4,246	8	4246
9	V	34	RENT		" "		6,540	6,540	9	6540
10	V	35	RENT-EQUIPMENT & VEH		" "		3,314	3,314	10	3314
11	V								11	
12	V								12	
13	V								13	
14	Total			$ 224,612			$ 105,402	$ * (119,210)	14	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6A

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6B

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6C

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6C

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
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Print Page 6D

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISES INC.								$		1
2	SHEL BELLOWS	MNGMT CNSLT.	ADMIN.	67.50	SEE ATTACHED	1.25	3.64	SALARY	7,710	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 7,710		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Preview

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS [Show Pgs 8A thru 8D] [Show Pgs 8E thru 8I] [Hide Pgs 8A thru 8I]

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES INC.
Street Address: 10700 W. HIGGINS ROAD, STE. 300
City / State / Zip Code: ROSEMONT, IL 60018
Phone Number: (847) 296-9625
Fax Number: (847) 298-0824

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	480,456	10	$ 72,138	$ 4,031	26,846	$ 4,031	1
2	17	ADMINISTRATIVE	PATIENT DAYS	480,456	10	137,976	7,710	26,846	7,710	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	480,456	10	35,987	0	26,846	2,011	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	480,456	10	13,291	0	26,846	743	4
5	21	CLERICAL	PATIENT DAYS	480,456	10	742,182	614,455	26,846	41,470	5
6	21	CLERICAL	DIRECT COST	1	1	27,926	27,926	1	27,926	6
7	24	TRAVEL	PATIENT DAYS	480,456	10	89,817		26,846	5,019	7
8	26	INSURANCE	PATIENT DAYS	480,456	10	42,804		26,846	2,392	8
9	30	DEPRECIATION	PATIENT DAYS	480,456	10	75,987		26,846	4,246	9
10	34	RENT	PATIENT DAYS	480,456	10	117,045		26,846	6,540	10
11	35	RENT-EQUIPMENT & VEH	PATIENT DAYS	480,456	10	59,305		26,846	3,314	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,414,458	$ 654,122		$ 105,402	25

Print Preview

Print Page 8A

STATE OF ILLINOIS

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8B

STATE OF ILLINOIS

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8C

STATE OF ILLINOIS

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8D

STATE OF ILLINOIS

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MEMBER LOANS	X		WORKING CAPITAL	DEMAND		150,000	150,000	DEMAND	0.0775	12,451	6
7	RELATED PARTIES	X		WORKING CAPITAL	DEMAND		721,000	721,000	DEMAND	SEE SCH	44,426	7
8												8
9	TOTAL Facility Related						$ 871,000	$ 871,000			$ 56,877	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 871,000	$ 871,000			$ 56,877	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$ 55,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 42,234	2
3. Under or (over) accrual (line 2 minus line 1).	$ (12,766)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 42,696	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 29,930	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998		11
1999	42,234	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,000 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 50,000 2. Number of Years Over Which it is Being Amortized: 60 MONTHS

3. Current Period Amortization: 11,833 4. Dates Incurred:

Nature of Costs: LEGAL COSTS

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		653,400		$	1
2					2
3	TOTALS	653,400		$	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	WALLCOVERING/BORDERS/VINYL COVERINGS			1999	17,944	2,564	7	2,564		4,367	9
10	STEEL DOORS			1999	2,337	85	27.5	85		140	10
11	SIGN, SIGN FOOTINGS AND BRICKS			1999	4,652	169	27.5	169		190	11
12	REMODEL-DINING & REC RM, OFFICES,HALLS			1999	73,951	2,689	27.5	2,689		3,250	12
13	CONDENSING UNIT FOR WALK IN FREEZER			2000	3,695	17	27.5	17		17	13
14	WATER SOFTENER			2000	10,120	46	27.5	46		46	14
15											15
16											16
17											17
18											18
19											19
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30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 5,570		$ 5,570	$	$ 8,010	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2

**Improvement type must be detailed in order for the cost report to be considered complete

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 64,067	$ 17,030	$ 6,236	$ (10,794)	3-15 YRS	$ 10,657	37
38	Current Year Purchases	37,171	5,872	2,806	(3,066)	3-15 YRS	2,806	38
39	Fully Depreciated Assets							39
40	RELATED PARTY	41,575	4,246	4,246			36,523	40
41	TOTALS	$ 142,813	$ 27,148	$ 13,288	$ (13,860)		$ 49,986	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 32,718	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 18,858	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (13,860)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 57,996	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: COUNTY OF BOONE
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		78	02/01/99	$ 29,167			3
4	Additions							4
5								5
6								6
7	TOTAL		78		$ 29,167 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 02/01/99
Ending 02/01/30

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2001	$ 48,333
13.	12/31/2002	$ 59,167
14.	12/31/2003	$ 87,500

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 6,280 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 17,568	$		$ 17,568	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,086			3,086	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			30,341			30,341	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				26,133		26,133	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, XRAY, RENTALS, I.V. THERAPY Other (specify):	39-2					13,426		13,426	13
14	TOTAL			$		$ 50,995	$ 39,559		$ 90,554	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,922	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	450,772		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,438		6
7	Other Prepaid Expenses	2,670		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 475,802	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	112,699		15
16	Equipment, at Historical Cost	101,238		16
17	Accumulated Depreciation (book methods)	(40,920)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	50,000		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(19,167)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 203,850	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 679,652	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 183,956	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,471		28
29	Short-Term Notes Payable	765,425		29
30	Accrued Salaries Payable	58,545		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,019		31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,696		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	1,602		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,081,714	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	173,107		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 173,107	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,254,821	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (575,169)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 679,652	$	48

***(See instructions.)**

Print Preview

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (318,128)	1
2	Restatements (describe):		2
3	ROUNDING ADJUSTMENT	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (318,126)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(257,043)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (257,043)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (575,169)	24 *

*** This must agree with page 17, line 47.**

Print Preview

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,813,723	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,813,723	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	1,944	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,944	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	626	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 626	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,554	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,554	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NET VENDING COMMISSIONS	5,634	28
28a	COUNTY JAIL MEAL REIMBURSEMENT	166,235	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 171,869	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,991,716	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 720,320	31
32	Health Care	1,351,934	32
33	General Administration	880,570	33
	B. Capital Expense		
34	Ownership	162,559	34
	C. Ancillary Expense		
35	Special Cost Centers	90,554	35
36	Provider Participation Fee	42,822	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,248,759	40
41	**Income before Income Taxes (line 30 minus line 40)****	(257,043)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (257,043)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Print Preview

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,837	1,935	$ 59,851	$ 30.93	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,475	8,838	177,304	20.06	3
4	Licensed Practical Nurses	15,195	16,423	271,719	16.55	4
5	Nurse Aides & Orderlies	37,801	40,661	394,429	9.70	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,081	4,539	68,045	14.99	8
9	Activity Director	1,969	2,115	26,308	12.44	9
10	Activity Assistants	4,610	5,013	38,121	7.60	10
11	Social Service Workers	1,953	2,083	24,354	11.69	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	6,698	7,269	85,657	11.78	14
15	Cook Helpers/Assistants	12,381	13,276	94,958	7.15	15
16	Dishwashers					16
17	Maintenance Workers	4,283	4,658	51,088	10.97	17
18	Housekeepers	9,077	9,702	61,279	6.32	18
19	Laundry	3,138	3,477	23,530	6.77	19
20	Administrator	1,997	2,074	57,800	27.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,906	4,455	57,320	12.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,825	1,927	18,952	9.83	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	119,226	128,445	$ 1,510,715 *	$ 11.76	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	173	$ 7,452	1-3	35
36	Medical Director	20	4,350	9-3	36
37	Medical Records Consultant	40	1,800	10-3	37
38	Nurse Consultant	905	34,709	10-3	38
39	Pharmacist Consultant	300	936	10-3	39
40	Physical Therapy Consultant	29	2,556	10a-3	40
41	Occupational Therapy Consultant	40	2,151	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	18	1,093	11-3	44
45	Social Service Consultant	49	2,842	12-3	45
46	Other(specify)				46
47	PSYCHO-SOCIAL CONSULTAN	61	3,558	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,635	$ 61,447		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	261	$ 8,786	10-3	50
51	Licensed Practical Nurses	1,388	37,699	10-3	51
52	Nurse Aides	7,520	125,433	10-3	52
53	TOTAL (lines 50 - 52)	9,169	$ 171,918		53

Print Preview

0

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARIE HARTZOG	ADMIN		$ 57,800
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 57,800

B. Administrative - Other

Description	Amount
	$
FIRST HEALTHCARE	224,612
TOTAL (agree to Schedule V, line 17, col. 3)	$ 224,612
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE ATTACHED SCHEDULE		161,754
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 161,754

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 27,108
Unemployment Compensation Insurance	29,922
FICA Taxes	113,853
Employee Health Insurance	56,333
Employee Meals	6,398
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	1,027
EMPLOYEE BENEFITS-OTHER	5,403
EMPLOYEE PHYSICAL EXAMS	801
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 240,845

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	8,762
Health Care Worker Background Check	240
(Indicate # of checks performed)	
ADV & PROMO/MARKETING	20,809
DUES & SUBSCRIPTIONS	877
LICENSES & PERMITS	552
TRUST FEES, CONTRIBUTIONS,etc.	1,250
MGMT CO ALLOCATION	743
LESS TRUST FEES, CONTRIB, etc.	(1,250)
Less: Public Relations Expense	( )
Non-allowable advertising	(20,214)
Yellow page advertising	(595)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,374

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	0
RELATED PARTY	5,019
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,019

**See instructions.

Print Preview

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2	PAINT/DECORATING												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Print Preview

Facility Name & ID Number MAPLE CREST CARE CENTRE # 0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? YES

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a politica action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 2,317 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 42,822
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 6,398 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned for providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID Number MAPLE CREST CARE CENTRE #0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
1	DIETARY			
	DIETITIAN CONSULTANT	XVIII B35	7452	
	REPAIRS & MAINTENANCE		0	
			0	7452
3	HOUSEKEEPING			
			0	
			0	0
4	LAUNDRY			
	EQUIPMENT REPAIRS & MAINTENANCE		936	
			0	936
5	HEAT & OTHER UTILITIES			
	GAS HEAT		35724	
	ELECTRICITY		41211	
	WATER		5497	
	CABLE TV - LOBBY		2031	
			0	84463
6	MAINTENANCE			
	GROUNDS MAINTENANCE		9874	
	PAINTING & DECORATING		922	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		27717	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1699	
	FIRE SERVICE		2201	
	DEFERRED PAINTING & DECORATING		1108	
			0	
			0	43521
7	OTHER			
	SCAVENGER		2480	
	SECURITY SERVICE		329	2809
9	MEDICAL DIRECTOR			
	MEDICAL DIRECTOR FEES	XVIII B36	4350	4350

LINE		SCHED REF		TOTAL
10	NURSING			
	CONTRACT NURSING	XVIII C53	171918	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		598	
	PSYCHO-SOCIAL CONSULTANT	XVIII B47	3558	
	RESTORATIVE NURSING CONSULTANT	XVIII B38	0	
	MEDICAL RECORDS CONSULTANT	XVIII B37	1800	
	PHARMACY CONSULTANT	XVIII B39	936	
	UTILIZATION REVIEW FEES	XVIII B	0	
	PHYSICIANS	XVIII B	0	
	PSYCHIATRIC	XVIII B	0	
	RN CONSULTANT	XVIII B38	34709	
			0	
			0	213519
10a	THERAPY			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B40	2556	
	OCCUPATIONAL THERAPY CONSULTAN	XVIII B41	2151	
	SPEECH THERAPY CONSULTANT	XVIII B43	0	
	RESPIRATORY CONSULTANT	XVIII B42	0	4707
11	ACTIVITIES			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B44	1093	
			0	1093
12	SOCIAL SERVICES			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B45	0	
	SOCIAL WORKER	XVIII B45	2842	
			0	2842
13	NURSE AIDE TRAINING			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number MAPLE CREST CARE CENTRE #0044172 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
14	PROGRAM TRANSPORTATION			
	PATIENT TRANSPORTATION		0	0
17	ADMINISTRATIVE			
	MANAGEMENT FEES	XIX B	224612	224612
18	DIRECTORS FEES		0	0
19	PROFESSIONAL SERVICES			
	DATA PROCESSING	XIX C	9062	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	152692	
	ACCOUNT COLLECTION FEES		0	161754
20	FEES,SUBSCRIPTIONS,PROMOTIONS			
	ENTERTAINMENT	VI 19 XIX F	0	
	ADV & PROMO/MARKETING	VI 25 XIX F	20214	
	EMPLOYEE WANT ADS	XIX F	8762	
	CONTRIBUTIONS	VI 20 XIX F	1250	
	DUES & SUBSCRIPTIONS	XIX F	877	
	LICENSES & PERMITS	XIX F	752	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	595	
	TRUST FEES/FRANCHISE TAX	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	H/CARE WORKER BACKGROUND CHECK	XIX F	240	32690
21	CLERICAL & GENERAL OFFICE EXPENSES			
	BANK CHARGES		241	
	EQUIPMENT REPAIR & MAINTENANCE		2179	
	OUTSIDE CLERICAL SERVICES		3099	
	PENALTIES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		234	
	TELEPHONE		14335	
	MESSENGER SERVICE		335	
			0	20423

LINE		SCHED REF		TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES			
	FICA TAXES	XIX D	113853	
	UNEMPLOYMENT COMPENSATION	XIX D	29922	
	WORKERS COMPENSATION INSURANCE	XIX D	27108	
	HOSPITALIZATION INSURANCE	XIX D	56333	
	EMPLOYEE BENEFITS - OTHER	XIX D	5403	
	EMPLOYEE PHYSICAL EXAMS	XIX D	801	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING CONTRIB	XIX D	1027	
	CHICAGO HEAD TAX	XIX D	0	234447
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS		6819	6819
24	TRAVEL & SEMINARS			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	0
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF		2950	2950
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE		41591	41591
27	OTHER			
	BAD DEBTS	VI 24	20145	
			0	20145
	GRAND TOTAL COLUMN 3 OTHER			1111123

MAPLE CREST CARE CENTRE - DIAGNOSTICS - 12/31/2000
This report reflects a 366-day year.
Page 3 Column 3 - Other is completely scheduled.
Total Salaries on Page 3 Line 29-1 = Page 20 Line 32-3.
Total Adj on Page 4 Line 45-7 = Page 5 Line 37.
Deferred maint. adj. on Page 5 Line 29-1 consists of 0 from Page 22 and 0 from Page 3 Line 6-3.
Related organization cost on Page 5 Line 34 = Page 6 Line 14-8.

Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.
Interest expense on Page 4 Line 32-4 = Page 9 Line 15-10.
Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.
Real estate tax accrual on Page 10 Line 4 = Page 17 Line 32-1.
Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 48-2.
Depreciation expense on Page 4 Line 30-8 = Page 13 Line 49-2.
Facility rent on Page 4 Line 34-4 = Page 14 Line 7-4.
Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.
Nurse aide training on Page 3 Line 13-8 = Page 15 Line 10-1.
Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.
Page 17 Assets = Liabilities & Capital.
Net income on Page 18 Line 7-1 = Page 19 Line 41-2.
Administrative Salaries on Page 3 Line 17-1 = Page 21-A.
Management fees on Page 3 Line 17-3 = Page 21-B.
Professional fees on Page 3 Line 19-3 = Page 21-C.
Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.
Dues, etc. on Page 3 Line 20-8 = Page 21-F.
Travel expenses on Page 3 Line 24-8 = Page 21-G.

Facility Name & ID Number MAPLE CREST CARE CENTRE #0044172
EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 COLUMN 3 OTHER LINES 2 AND 22

TOTAL FOOD PURCHASE	22964	PATIENT MEALS	80538
LESS SALES TAX	-1667	ADD EMPLOYEE MEALS	27816
NET FOOD	24631	TOTAL MEALS/YEAR	108354
TOTAL PATIENT CENSUS	26846	NET FOOD	24631
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	108354
TOTAL PATIENT MEALS	80538	COST PER MEAL	0.23
		TIME EMPLOYEE MEALS	27816
ADD # EMPLOYEE MEALS/DAY	76		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	6398
TOTAL EMPLOYEE MEALS	27816		

MAPLE CREST CARE CENTRE - COMPARISONS - 12/31/2000

	ref.	12/31/2000			12/31/1999			DIFF	12/31/1998		
CAPACITY DAYS		28548			26052			-26052	0		
CENSUS DAYS		26846			25286			-25286	0		
OCCUPANCY %		0.94038111			0.97059727						
SALARIES											
TOTAL General Services	8-1	316512	0.10975633	11.7899128	288105	0.11854543	11.3938543	-288104.89	0		
Social Services	12-1	24354	0.0084452	0.90717425	20275	0.00834247	0.8018271	-20274.992	0		
TOTAL Health Care and Programs	16-1	1079083	0.37419177	40.1952991	852013	0.35057445	33.6950486	-852012.63	0		
Clerical & General Office Expenses	21-1	57320	0.01987676	2.13514118	48772	0.02006802	1.92881436	-48771.98	0		
TOTAL General Administration	28-1	115120	0.03991997	4.28816211	99415	0.0409059	3.93162224	-99414.96	0		
TOTAL Operation Expense	29-1	1510715	0.52386806	56.2733741	1239533	0.51002578	49.0205252	-1239532.5	0		
ADJUSTED TOTALS											
Food	2-8	14899	0.0051665	0.55498026	42957	0.01767535	1.69884521	-42956.995	0		
Heat and Other Utilities	5-8	84463	0.02928909	3.14620428	64854	0.02668522	2.56481848	-64853.971	0		
Maintenance	6-8	123695	0.0428935	4.60757655	82782	0.03406198	3.27382741	-82781.957	0		
TOTAL General Services	8-8	546090	0.1893667	20.3415779	486178	0.20004576	19.2271613	-486177.81	0		
Administrative	17-8	62325	0.02161233	2.32157491	58054	0.02388725	2.29589496	-58053.978	0		
Directors Fees	18-8				0			0	0		
Professional Services	19-8	162914	0.05649341	6.06846458	95696	0.03937566	3.78454481	-95695.944	0		
Fees, Subscriptions, Promotions	20-8	11374	0.00394414	0.42367578	29712	0.01222548	1.17503757	-29711.996	0		
License Fee-IDPA	Pg21	200	6.9354E-05	0.0074499	200	8.2293E-05	0.00790952	-199.99993	0		
License Fee-Other	Pg21	552	0.00019142	0.02056172	1899	0.00078137	0.07510085	-1898.9998	0		
Clerical & General Office Expenses	21-8	166374	0.05769323	6.19734784	158906	0.06538443	6.28434707	-158905.94	0		
Employee Benefits & Payroll Taxes	22-8	240845	0.08351741	8.97135514	228580	0.09405292	9.03978486	-228579.92	0		
Payroll Taxes	Pg21	143775	0.04985661	5.35554645	122424	0.05037332	4.84157241	-122423.95	0		
W/C Insurance	Pg21	27108	0.00940019	1.00975937	17891	0.00736154	0.70754568	-17890.991	0		
Health Insurance	Pg21	56333	0.0195345	2.09837592	79701	0.03279426	3.15198133	-79700.98	0		
Inservice Training & Education	23-8	6819	0.00236461	0.25400432	4136	0.00170182	0.16356877	-4135.9976	0		
Travel and Seminar	24-8	5019	0.00174043	0.18695523	3991	0.00164216	0.15783437	-3990.9983	0		
Other Admin. Staff Transportation	25-8	2950	0.00102297	0.10988602	1910	0.0007859	0.07553587	-1909.999	0		
Insurance-Prop.Liab.Malpractice	26-8	43983	0.01525191	1.63834463	36703	0.01510204	1.45151467	-36702.985	0		
Other (specify):*	27-8				0			0	0		
TOTAL General Administration	28-8	702603	0.24364044	26.1716084	617688	0.25415766	24.428063	-617687.76	0		
TOTAL Operation Expense	29-8	2591149	0.89852832	96.5189972	2277352	0.9370531	90.0637507	-2277351.1	0		
Real Estate Taxes	33-3	29930	0.01037878	1.11487745	55000	0.02263063	2.17511667	-54999.99	0		
Real Estate Legal	Pg10	0			0			0	0		
GRAND TOTAL COST	45-8	2883770	1	107.418982	2430334	1	96.1138179	-2430333	0		
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		1076660.72	0.3733518	40.1050704	946747.85	0.38955463	37.4415823	-946747.48	#DIV/0!	#DIV/0!	#DIV/0!

MAPLE CREST CARE CENTRE
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2000

INCOME PER F/S									2,717,091	
	NURSING	EMPL BENEI	PLANT	LAUNDRY	DIETARY	GENL/ADMI	OTHER INC/I	CAPITAL		SALARIES
PER COST REPORT	1,351,934	234447	294908	35547	389865	646123	42822	162559		1510715
ADJUSTMENTS:										
EQUIP RENTAL/AUTO LEASE	2480		585			3215		-6280		
CABLE TV	0		-2031			2031				
CONTRACT NURSING										171918
INTEREST INCOME							(3,554)			
NET VENDING COMMISSIONS							-5634			
EMPLOYEE PHYSICAL EXAMS		-801				801				
INSURANCE - EXECUTIVE LIFE		0				0				
MANAGEMENT FEES						-224612		224612		
BAD DEBTS						-20145	20145			
NURSE AID REIMB-STATE							-626			
PROFIT SHARING										
PRIOR EXPENSES							-6078			
RECLASSED SALARIES	0					0				
RECLASSED SALARIES										
DISCOUNTS/JAIL MEAL REIMB							-166235			
ANCILLARY/OXYGEN INCOME	0						-1944			
TOTAL COSTS	1354414	233646	293462	35547	389865	407413	-121104	380891	2974134	1682633
PER FINANCIAL STATEMENTS	1354414	233646	293462	35547	389865	407413	-121104	380891	-257043	1682633
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									-257043	